Guidance for Clinical Documentation Improvement Programs

Healthcare consumers are unique. Each person has his or her own combination of medical conditions that organizations must somehow standardize for data comparison. One way to capture these data is by translating clinical documentation into codes such as ICD-9-CM and CPT.

Historically, in the inpatient setting, data collection occurred after the patient was discharged. After discharge, HIM professionals checked the record for discrepancies that could hinder code assignment. HIM professionals would then query the provider for clarification. (For purposes of this practice brief, the term "query" will be used to identify any physician communication tool.)

However, with the implementation of the prospective payment system, coded data took on greater significance and became a mechanism for reimbursement, quality measure reporting, and profiling. The increased need for interpreting coded data for meaningful comparison and quality reporting has led to the expansion of the HIM professional's role in clinical documentation improvement (CDI).

The focus of most CDI programs is on improving the quality of clinical documentation regardless of its impact on revenue. Arguably, the most vital role of a CDI program is facilitating an accurate representation of healthcare services through complete and accurate reporting of diagnoses and procedures.

A successful CDI program can have an impact on Centers for Medicare and Medicaid Services quality measures, present on admission, pay-for-performance, value-based purchasing, data used for decision making in healthcare reform, and other national reporting initiatives that require the specificity of clinical documentation.

Improving the accuracy of clinical documentation can reduce compliance risks, minimize a healthcare facility's vulnerability during external audits, and provide insight into legal quality of care issues.

This practice brief provides an overview of key elements in establishing, maintaining, or enhancing a CDI program. This can be achieved through a variety of methods and structure that are tailored to the unique needs of the healthcare entity.

The following guidance does not replace the 2008 AHIMA practice brief "Managing an Effective Query Process." It is, however, intended to provide greater specificity and detail related to CDI programs.

Policies and Procedures

The CDI department must be governed by written policies and procedures. These policies and procedures should be developed with the assistance of other departments affected by clinical documentation, including compliance, case management, and HIM.

CDI policies can include (but are not limited to) education, experience, and credentials for hiring CDI professionals; initial orientation and training; ongoing education and training; compliant query practices; and a CDI quality assurance process.

Additional policy and procedure examples can be found in Appendix B: Examples of Policies and Procedures.

A well-constructed CDI program framework will include comprehensive policies and procedures that will facilitate a successful, yet compliant CDI program.

Roles, Competencies, and Staffing Models

When it comes to documenting clinical encounters, providers are expected to provide legible, complete, clear, consistent, precise, and reliable documentation of a patient's health history, present illness, and course of treatment. This documentation includes observations, evidence of medical decsion making in determining a diagnosis, treatment plan, and outcomes of all tests, procedures, and treatments.

Clinical documentation should be as complete and specific as possible and include information such as level of severity, specificity of anatomical sites involved, and etiology of symptoms.

The CDI Role

CDI professionals can help providers achieve complete and accurate documentation by:

- Facilitating and obtaining appropriate provider documentation within the health record for clinical conditions and treatment required for accurate representation of severity of illness, expected risk of mortality, and complexity of care of the patient
- Exhibiting thorough knowledge of clinical documentation requirements as they relate to the classification systems, MS-DRG assignment, and clinical conditions and treatment needs of the patient population
- Educating members of the patient care team and others regarding documentation guidelines

A feature of the CDI process is conducting concurrent reviews of the health record. Depending on the relationship between the CDI program and the HIM department, the CDI staff may hand off records to the HIM department following discharge or they may continue to follow up on open questions before the final billing process.

Some CDI programs conduct retrospective reviews, while others leave this to the HIM department. Regardless of when the reviews are conducted, the goal is to clarify ambiguous, conflicting, or incomplete documentation.

The CDI professional works to facilitate the overall quality and completeness of clinical

documentation to accurately represent the severity, acuity, and risk of mortality profile of the patient being treated.

CDI Competencies

Those who typically fill CDI roles include, but are not limited to, HIM professionals, nurses, physicians, and other healthcare professionals with a clinical or coding background. It is recommended that healthcare entities employ, educate, and train qualified individuals to perform the CDI role.

Key skills and competencies for those in CDI roles include:

- Knowledge of coding concepts and guidelines and clinical terminology
- Ability to read and analyze all information in a patient's health record
- Clinical knowledge (anatomy and physiology, pathophysiology, and pharmacology)
- Ability to establish and maintain strong verbal and written communication with providers and other clinicians
- Knowledge of healthcare regulations, including reimbursement and documentation requirements

A sample job description can be found in AHIMA's "Clinical Documentation Improvement Toolkit," available online at www.ahima.org.

Those who perform the CDI function should be familiar with relevant ethical practices and should refer to industry guidance for assistance in decision-making processes and actions, expectations for making ethical decisions in the workplace, and demonstrating the CDI professional's commitment to integrity. AHIMA's "Clinical Documentation Improvement Toolkit" offers a source for this information.

The guidance is relevant to all CDI professionals and those who manage the CDI function, regardless of the healthcare setting in which they work or whether they are AHIMA members.

CDI Program Staffing Models

Those who typically fill CDI roles include, but are not limited to, HIM professionals, nurses, physicians, and other healthcare professionals with a clinical or coding background. Organizations can staff their CDI programs using one of two general models:

Single Discipline Models

- HIM professionals—HIM professionals with compliance knowledge or experience have an added benefit to the HIM staffing profile (RHIA or RHIT and preferably a CCS credential also).
- Registered nurses—RNs with case management or utilization review experience have an added benefit to this model.
- Physicians, physician assistants, or other providers—physician clinical experience is an added benefit, but compensation may be a factor.

Hybrid Models

- HIM professionals and RNs—two disciplines work together performing the concurrent documentation review. This model also provides nursing clinical expertise and the HIM expertise within the concurrent program.
- Multidisciplinary—RNs, physicians, physician assistants, and HIM professionals all review the health record concurrently and communicate with providers.

CDI Staffing Models

CDI programs use a variety of staffing models. The program may be staffed with one or more healthcare disciplines (e.g., HIM professionals, registered nurses, or other clinical staff). Factors that may influence an organization's choice include patient volume, availability of qualified staff, and staff compensation.

The sidebar above offers examples of staffing models. While these models may not be ideal for all healthcare organizations, they do provide guidance for professional credentials and experience.

A strong consideration for the staffing model is the inclusion of a physician advisor. (For purposes of this practice brief, the term "physician advisor" encompasses related terms such as physician champion and physician liaison.) This role can conduct reviews, communicate with other physicians or providers about documentation issues, and promote open lines of communication, particularly when there is a lack of response to queries. The physician role may vary greatly in response to the needs of each program.

From an organizational reporting relationship, CDI professionals typically report to the chief financial officer or within the HIM, quality, compliance, or case management departments.

A recent industry survey indicated a shift in reporting structure to HIM.[1] This may be a result of the key skills HIM professionals provide to support this reporting mechanism. HIM professionals have core fundamental skills associated with documentation, coding, compliance, and information management that lend to documentation improvement.

Role of the CDI Physician Advisor

In general, the CDI physician advisor acts as a liaison between the CDI professional, HIM, and the hospital's medical staff to facilitate accurate coding, DRG assignment, and representation of severity, acuity, and risk of mortality.

The physician advisor is responsible for educating physicians and other providers on the link between ICD-9-CM coding guidelines and clinical terminology to improve their understanding of severity, acuity, and risk of mortality and DRG assignments on their individual patient records.

The advisor is also in charge of educating specific medical departments (e.g., internal medicine, surgery, family practice) at department meetings regarding the importance of complete and accurate disease reporting for physician performance profiling, physician E & M payment and pay-for-performance, and appropriate hospital reimbursement and profiling for patient care. Education should also include ways to provide improved health record documentation that specifically affects

ICD-9-CM code and DRG assignment and capture of severity, acuity, and risk of mortality.

The physician advisor should also assist with CDI articles in the hospital newsletter or other communication vehicles to further educate the medical staff.

The physician advisor should work with the HIM and CDI personnel on a routine basis to review selected health records concurrently or retrospectively. The advisor should explain documentation issues found in chart review including common issues such as congestive heart failure, chronic kidney disease, urosepsis, pneumonia, anemia, and respiratory failure.

The advisor should also help develop clinically appropriate and compliant provider queries to further clarify documentation.

The advisor should facilitate complete health record documentation by addressing admission denials, DRG modifications, and repetitive queries. Communicating with third-party payers regarding admission denials, DRG changes, and other issues and aiding in quality assurance, Medicare core measures, and other initiatives also comes under the purview of the physician advisor.

Query Process

Another key element of the CDI process is provider communication. Prior to CDI programs, the query process was the responsibility of HIM professionals; however, depending on the staffing model, the CDI professional either shares the query role with HIM professionals or assumes complete responsibility of the process.

HIM professionals are familiar with AHIMA guidelines regarding the coding and query process; however, CDI professionals from other disciplines may be less familiar with these guidelines, their application, and impact.

Organizations require comprehensive, facility-specific policies and procedures that govern the CDI clarification process. These should include, but are not limited to, when and how to format an appropriate question to a provider (verbal and written queries), query retention, and conducting audit and monitoring activities to determine the appropriateness and effectiveness of the CDI program. Comprehensive information regarding the query process can be found in the 2008 AHIMA practice brief “Managing an Effective Query Process.”

A query is a routine communication and education tool used to advocate complete and compliant documentation. Although AHIMA refers to this communication to providers as a “query,” CDI programs may use different names, such as clinical clarification, documentation alerts, and documentation clarification. Regardless of what the communication is called, the query should adhere to the guidance outlined in the 2008 practice brief “Managing an Effective Query Process” and this current practice brief.

Typical situations addressed by a query include presenting clinical indicators of an undocumented condition, requesting further specificity or the degree of severity of a documented condition, clarifying a potential cause and effect relationship, and addressing present on admission issues. The communication can include verbal and written queries, whether concurrent or retrospective. Some organizations may primarily rely on one strategy, while others may use a variety of query methods.

Written and Template Queries

Written queries provide clinical indicators to support the clarification being presented to the provider. They are especially useful to new CDI programs and staff as templates, which can be used to standardize the query process.

Ensuring all queries contain consistent information (e.g., patient name, admission date, and medical record number) is an advantage of written queries; however, using templated queries by condition could be problematic if they do not provide patient-specific clinical indicators. Although it may be convenient to use a standard query for particular conditions such as congestive heart failure, the standard query should be individualized to each patient and contain clinical evidence specific to the case.

Other issues that may be encountered when using written queries include how to notify the provider of the presence of the query; making sure the provider understands the query; and verifying that the query is addressed appropriately in the health record. Many facilities struggle with making queries visible to providers, as many different healthcare providers use the chart. A possible solution is to electronically notify the provider when a query is placed.

Knowing when and how the query has been answered is more difficult to address. There is much variation among CDI programs regarding how to follow up on an open or incomplete query. Some CDI programs follow the query to closure, while in other programs the HIM professionals follow up on the open queries. Organizations require a clear procedure on addressing open queries, which should include how to deal with a lack of response by the provider and how to address a response on the query form instead of the health record.

Template queries should not be titled with a diagnosis that has not already been documented in the health record, as this may prejudice the provider's response. For example, if anemia is not already documented in the health record then the written query should not be titled "anemia." However, if anemia is already documented in the health record, then a written query may be titled "anemia" and seek additional specificity regarding the type.

Query Timeliness and Interpretation

One of the more difficult issues with written queries is timeliness and provider interpretation of the query. The timing of a query is important, as providers may be reluctant to document a condition that has already been treated and no longer requires immediate treatment (e.g., acute renal failure and asthma exacerbation). Often providers disagree with a query if they do not understand the issue posed.

The role of the CDI professional is to bridge the gap between the clinical language used by providers and what can be captured by ICD-9-CM codes while preserving the provider's intent. CDI professionals must craft their queries skillfully. The query should assist the physician in understanding the documentation problem without leading the provider to a particular conclusion.

Leading versus Nonleading Queries

Queries may take many forms, but they are never intended to lead the provider to one desired outcome. The following examples emphasize the difference between leading and nonleading

queries.

Clarification for Specificity of a Diagnosis

Obtunded patient admitted with three-day history of nausea and vomiting. CXR revealed right lower lobe (RLL) pneumonia. Clindamycin ordered.

Leading query: Is the patient's pneumonia due to aspiration?

Nonleading query: Can the etiology of the patient's pneumonia be further specified? It is noted in the admitting history and physical examination (H&P) this obtunded patient had a history of nausea and vomiting prior to admission to the hospital and is treated with clindamycin for RLL pneumonia. Based on the above, can the etiology of the pneumonia be further specified? If so, please document the type/etiology of the pneumonia in the progress notes.

Clarification of a Missing or Vague Diagnosis

Patient admitted with COPD exacerbation. H&P notes respiratory distress. Oxygen saturation on admission is 86 percent on room air, respiratory rate of 28, and arterial blood gas (ABG) results of pO^2 45, pCO^2 50, pH 7.34, with Bipap and oxygen ordered.

Leading query: The patient has abnormal ABGs and your documentation reflects respiratory distress. If you mean acute respiratory failure, please document on this form or the progress note. Thank you.

Nonleading: Can your documentation of respiratory distress be further clarified:

- Acute respiratory insufficiency: _____
- Acute respiratory failure: _____
- Acute on chronic respiratory failure: _____
- Some other cause of respiratory distress: _____
- Undetermined: _____
- Not applicable: _____

Rationale: It is noted in the H&P this patient admitted with acute exacerbation of COPD with oxygen saturation on admission of 86 percent on room air, respiratory rate of 28, and ABGs of pO^2 45, pCO^2 50, pH 7.34, with Bipap and oxygen ordered.

Verbal Queries

For CDI professionals, not all verbal interactions with providers are queries. In many CDI programs staff accompany the medical team on rounds as they discuss patients. These interactions are not considered verbal queries because the provider team determines which patients are discussed and the CDI professional is usually providing general education rather than addressing documentation issues.

The advantage of a verbal query is the ability to interact with the provider to facilitate understanding of the issues that need to be addressed. However, caution must be used to ensure that the provider is allowed to make his or her own conclusions regarding the appropriateness of a particular diagnosis

or service.

There might be variation among how the CDI professional poses verbal queries, and relationships with members of the medical staff may also affect how verbal queries are presented. Staff members who have a more informal relationship with the provider could inadvertently create a leading query.

Another advantage of the verbal query is the opportunity to obtain immediate feedback. The CDI professional knows at once the provider's response to the query, and the provider can immediately document it in the health record. In addition, the conversation can provide an educational opportunity for the CDI professional.

One of the main challenges of a verbal query is accurate documentation of the interaction. What, where, and how it should be documented are all issues to be addressed by policies and procedures.

Organizations should have a permanent record of verbal query language used in order to demonstrate compliance and allow for adequate quality assurance monitoring. A CDI checklist is available below. A sample of a quality assurance monitoring tool is available in the "Clinical Documentation Improvement Toolkit" at www.ahima.org.

Query Retention

Retention of the query varies by healthcare organization. First, an organization must determine if the query will be part of the health record. If the query is not part of the health record, then the organization must decide if the query is kept as part of the business record or only the outcome of the query is maintained in a database.

Before this decision is made a discussion with the facility compliance and legal staff may be beneficial. Regardless, the query should be retained indefinitely if it contains information not documented in the health record. Auditors may request copies of any queries in order to validate the query wording, even if they are not considered part of the legal medical record.

With the current culture of governmental audits (e.g., RACs and MACs), it is helpful to keep the query a permanent part of the health record to demonstrate compliant and ethical CDI practices. The permanent query demonstrates the CDI professional's attempt to seek clarification. It also can demonstrate to the administration the CDI professional's efforts to communicate to the medical staff.

Keeping the query as part of the health record can also refute a healthcare provider's assertion that he or she was unaware of the need for additional documentation. Finally, a permanent document in the health record serves to reduce redundancy and decrease the risk of a duplicate, retrospective query.

Leading versus Nonleading Queries

The query process helps healthcare providers properly, effectively, and accurately capture their medical decision-making process as explicit clinical documentation in the health record. The AHIMA practice brief "Managing an Effective Query Process" is a comprehensive resource for creating and managing the query process.

There is more than one way to write a query, and the examples provided in the sidebar above are

formatted differently to illustrate this point. Regardless of format, a query is never intended to lead the provider to one desired outcome. The query must provide reasonable clinically supported options, include clinical indicators, and must not result in a yes/no answer (with the exception of present on admission status). They must include the option that no additional documentation or clarification can be provided.

See Appendix C: Examples of Leading and Nonleading Query Examples.

Appendix A: Checklist for Written and Verbal Queries

WRITTEN QUERIES SHOULD contain standard documentation with precise language and identification of clinical indicators necessary for appropriate provider response.

Organizations should outline the following processes for written and verbal queries.

Written Queries

All written queries should include the following standard elements:

- Patient name
- Admission date and time
- Account number
- Medical record number
- Date the query is initiated
- Contact information of the CDI professional
- Individualized diagnosis-specific templates to the particular patient, which provide clinical evidence relevant to the particular patient

Organizations should also outline the following procedures for written queries:

- A protocol to identify where queries are placed in the medical record
- A process for notifying the medical staff of the presence of a query in the medical record
- A protocol to address open (concurrent) queries, including:
    - How frequently open queries will be addressed
    - How long queries are allowed to remain unanswered or open
    - How queries opened under concurrent review are addressed when the patient is discharged without a response
- A protocol for query maintenance
- A QA process of written queries, including:
    - Who will monitor the written queries
    - How many queries will be reviewed for compliance and how often
    - The feedback and corrective action needed, including who will take corrective action and when
    - Reporting documents for CDI QA processes

Verbal Queries

Organizations should outline the following procedures for verbal queries:

- When verbal queries are appropriate
- An initial and ongoing training process that includes mentoring and testing trainees and a process for ongoing compliance monitoring
- A process for documenting the verbal queries
- A QA process of verbal queries, including:
    - Who will monitor the verbal queries
    - How many queries will be reviewed for compliance and how often
    - The feedback and corrective action needed
    - Reporting documents for CDI QA processes

Appendix B: Examples of Policies and Procedures

The CDI department must be governed by written policies and procedures. These policies and procedures should be developed with the assistance of other departments affected by clinical documentation, including, compliance, case management, and HIM.

The following list provides a sample of possible policies and procedures are that may be used for new or existing CDI programs:

- CDI Position Statement
- CDI Orientation and Competency Process
    - CDI Quality Assurance Process
- CDI Review Process
    - CDI Concurrent Review
    - CDI Retrospective Review
    - CDI Post-bill Review
- Compliant Query Process
    - Query Format
    - Unanswered Physician Query
    - Verbal Query Documentation
    - Retention of CDI Query Documentation
- Physician Advisor/Champion Process
- CDI Metrics/Reporting Process

Appendix C: Examples of Leading and Nonleading Query Examples

Clarification for Specificity of a Diagnosis

A patient is admitted for a right hip fracture. The H&P notes that the patient has a history of chronic congestive heart failure. A recent echocardiogram showed left ventricular ejection fraction (EF) of 25 percent. The patient's home medications include metoprolol XL, lisinopril, and Lasix.

Leading: Please document if you agree the patient has chronic diastolic heart failure.

Nonleading: It is noted in the impression of the H&P that the patient has chronic congestive heart failure and a recent echocardiogram noted under the cardiac review of systems reveals an EF of 25 percent. Can the chronic heart failure be further specified as:

- Chronic systolic heart failure_____
- Chronic diastolic heart failure_____
- Chronic systolic and diastolic heart failure_____
- Some other type of heart failure _____
- Undetermined_____

Clarification for Specificity of a Diagnosis

A patient is admitted with a gastrointestinal bleed per the admission note. On admission the hemoglobin is 7.8gm/dl and hematocrit is 20.4 percent. The H&P states anemia. The patient is treated with two units packed red blood cells (PRBCs).

Leading: The patient has received two units of PRBCs with hemoglobin of 7.8 and hematocrit of 20.4. Please document acute blood loss anemia in the area above if you agree.

Noneading: Can your documentation of anemia be further specified as:

- Acute blood loss anemia: _____
- Chronic blood loss anemia: _____
- Other type of anemia: _____
- Undetermined: _____

The medical record reflects the following clinical indicators:

Check If Indicator Is Present	Clinical Indicator	Location
X	Anemia	H&P
X	Significant drop in hemoglobin and hematocrit	Laboratory report: hemoglobin 7.8; hematocrit 20.4
	Hypotension	
X	GI bleed	Admission note
X	Transfusion(s)	Physician order; blood bank record
	Acute bleed—other sites	
	Tachycardia	

Clarification of a Missing or Vague Diagnosis

A patient is admitted with pneumonia. The admitting H&P examination reveals WBC of 14,000; a respiratory rate of 24; a temperature of 102°F; heart rate of 120; hypotension; and altered mental status. The patient is administered an IV antibiotic and IV fluid resuscitation.

Leading: The patient has elevated WBCs, tachycardia, and is given an IV antibiotic for Pseudomonas cultured from the blood. Are you treating for sepsis?

Nonleading: Based on your clinical judgment, can you provide a diagnosis (e.g., pneumonia, sepsis, septicemia, another diagnosis, or undetermined) that represents the below-listed clinical indicators?

In this patient admitted with pneumonia, the admitting history and physical examination reveals the following:

- WBC 14,000
- Respiratory rate 24
- Temperature 102° F
- Heart rate 120
- Hypotension
- Altered mental status
- IV antibiotic administration
- IV fluid resuscitation

Please document the condition and the causative organism (if known) in the medical record.

Physician Query for Urosepsis

Dear Dr. _____:

Since **"urosepsis"** is a nonspecific entity for coding purposes, can you further clarify if this patient had a URINARY TRACT INFECTION or either SEPSIS, SEVERE SEPSIS FROM A URINARY SOURCE, some other condition, or undetermined based on multiple clinical findings documented in the medical (as circled):

Documentation for sepsis:

1. Fever (oral temperature > 38°C or 100.4°F) or hypothermia (oral temperature < 36°C or 96.8°F)
2. Leukocytosis (white count > 12,000) or Leukopenia (white count < 4,000 or > 10 percent bands)
3. Tachycardia (> 90 beats per minute)
4. Tachypnea (respiratory rate > 20 breaths per minute or a pCO2 of < 32 mm Hg)
5. Altered mental status
6. Oliguria (< 30 ccs per hour)
7. Hypotension (systolic blood pressure < 90 mm Hg or a 40 mm Hg drop from the previous normal blood pressure responding to fluid resuscitation)
8. Evidence of hypoperfusion (increase anion gap, reduced arterial pH, elevated lactate level, and reduced skin perfusion)
9. Hyperglycemia, unexplained
10. Elevated biomarkers (C-reactive protein, procalcitonin, Interleukin-6)

Documentation for severe sepsis (sometimes referred to as sepsis syndrome)**:**

1. Acute renal failure (creatinine > 2 x ULN or baseline)
2. ARDS (PaO2/FiO2 < 250)
3. DIC (thrombocytopenia— platelet count < 100,000)
4. Encephalopathy

5. Hepatic failure (bilirubin or SGOT > 2 x ULN)

Appropriate treatment for sepsis/severe sepsis:

1. Broad spectrum antibiotics
2. IV fluid resuscitation
3. Vasopressor therapy (such as with Dopamine)
4. Clotting factors or platelet transfusion
5. Xigris infusion

Please document your response either in the final progress note or discharge summary.

Note

1. HCPro. "Survey: HIPAA Sanctions Policy." Compliance Monitor. November 25, 2009. Available online at www.hcpro.com/CCP-242626-862/Survey-HIPAA-sanctions-policy.html.

Resources

AHIMA. "Clinical Documentation Improvement Toolkit." 2010. Available online at www.ahima.org.

AHIMA. "Managing an Effective Query Process." *Journal of AHIMA* 79, no. 10 (Oct. 2008): 83–88.

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